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ABSTRACT

This paper addresses some of the ethical and legal components of the issue of adolescence and the right to die. Developmental aspects on which psychologists may be uniquely qualified to comment are also addressed. The paper looks at ethical aspects of right to die decisions, the principle of autonomy, and the responsibility of caregivers. Legal aspects of such decisions are also considered, and several legal precedents are cited along with the issue of competence. Two case studies are examined in light of these issues. The paper concludes with some thoughts on the role of psychologists in such cases, e.g., counselor, assessor of competence level, and expert witness. (JAC)

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Adolescence and the Right to Die:

Issues of Autonomy, Competence and Paternalism.

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Introduction

Greuling and DeBlassie (1980) identify suicide as the second highest cause of death among adolescents, behind only accidents. Rosenkrantz (1978) cites figures of more than 4000 successful suicides among adolescents annually in the U.S., and notes that the rate has tripled since the 1950's. The most conservative estimate of frequency of attempted suicide among adolescents that he proposes is 20:1, suggesting that somewhere in excess of 80,000 adolescents attempt suicide annually in the U.S. In the light of these figures the likelihood of psychologists being involved with adolescents who express a desire to die is increasing rapidly.

Whiting (1981) notes that the incidence of depression among adolescents is also increasing, and identifies such contributing factors as family disruption, mobility, increased drug abuse, extended adolescence and student unrest. Currently, one might add factors such as unemployment, and extreme competition in seeking employment. The link between depression and a desire to die are well established. Psychologists are frequently the "front-line" of treatment for such adolescents with doubts about the value of their lives.

On a different front, "modern technology has greatly increased the ability of the physician and the well-equipped hospital to maintain indefinitely the life of patients with very slim prospects for recovery to anything approaching normal function." (Rosoff, 1981, p. 269) Many of these patients are alert adolescents. Some of them are not sure life is worth living.

Psychologists are increasingly involved as therapists, counselors and psychological assessors, and may particularly be involved in determining the adolescent's competence to make decisions terminating his or her own life.

These tasks will continue to fall to psychologists with increasing frequency. However, because right-to-die issues are such an emotive, gray area, expectations of the role of psychologists remain unclear. What is clear is that increasingly difficult questions are likely to be asked of them, and increasingly difficult decisions are likely to be required of them.

It is the purpose of this paper to address some of the ethical and legal components of the issue of adolescence and the right-to-die. Developmental aspects, in which psychologists may be uniquely qualified to comment, will also be addressed. The paper will look first at ethical and legal issues, examine two cases in the light of these, and conclude with some thoughts on the role of psychologists in such cases.

PART I

ETHICAL ASPECTS OF RIGHT TO DIE DECISIONS

Is it ever morally responsible, or acceptable, for a psychologist to support a person's desire to die? Before attempting to answer such a question, relevant ethical principles need to be recognized.

Western society holds dearly the concept of personal autonomy. "A person's autonomy is his or her independence, self-reliance, and self-contained ability to decide." (Beauchamp and Childress, 1979, p. 56) While many of us

would want to impose some restrictions, few would disagree that in self-regarding actions our freedom should be maximized. Some appear to see autonomy as an absolute ethical standard, one that should never be over-ridden. Thomas Szasz (1971) appears to come close to this view in relation to right to suicide decisions. However, many more see autonomy as prima facie binding, i.e. we have a bound duty to observe this principle unless it is in conflict with another ethical principle, judged in the circumstances to carry more weight. In simple parlance, autonomy is not absolute, but if we over-ride it, we'd better have a good (ethical) reason! Clearly, the principle of autonomy, however we view it, is central in any ethical discussion of right to die cases.

At this stage it is important to note that the principle of autonomy is based solidly upon presumptions of a person's competence. Where a person is judged to be incompetent, as for example, a newborn child, a retarded adult, or a comatose adolescent, the principle of autonomy is much harder to apply. Such people are seen to be restricted by their particular "afflictions" in such a way that they are not currently free to self-determine their lives. Because competence is more a legal, and psychological, issue it will receive fuller discussion in the next section. Enough to note, at this stage, that autonomy largely presupposes competence.

What other ethical principles are relevant in right to die cases? The most obvious ones are those that traditionally bind caregivers - non-maleficence and beneficence. Beauchamp and Childress (1979) describe the principle of nonmaleficence as the requirement that we do no harm to others. They delineate the principle of beneficence as referring to "acts involving

prevention of harm, removal of harmful conditions, and positive benefiting..." (p. 135). While virtually no one, if pressed, would see these as absolute, they do appear to be prima facie duties. To reiterate, the concept of a principle being prima facie binding, simply means that our conduct ought to be guided by it, unless a conflicting ethical principle, with stronger claims in the circumstances, is also operating.

When the principle of beneficence is invoked to justify "conferring benefits" upon someone, even though that person has expressly indicated a wish not to have the "benefit", most ethicists speak of this as paternalism. Thus a care giver might coerce a drug abuser to undergo a course of treatment which he or she does not desire, because it is "for the best". Such an action would be paternalistic. Paternalistic actions deriving from the principle of beneficence, are nonetheless, often questioned simply because they appear to over-ride the principle of autonomy.

This, in essence, is the classic conflict of ethical principles in right to die cases. Do we have the right to forcefully protect people from the potential harm their own decisions may bring? If a person wants to die, do we have any ethical right to prevent them? Are there situations in which beneficence, expressed in paternalism, should take precedence over autonomy? Does the answer to these questions differ, depending upon the person's age?

Most writers who believe that paternalism can take precedence over autonomy, set up strict guidelines to clarify when this is ethically justified (Beauchamp and Childress, 1979; Childress, 1981; Gert and Culver, 1979). For Gert and Culver (1979), for example, this means that the evil prevented

by paternalism be considerably greater than the evil that would occur for the person if his or her autonomous decision were not over-ridden. It also means that there must be some doubt about the person's rationality, and that the paternalistic behavior is such that one could universally allow it to take precedence over autonomy in these circumstances.

A Digression: Who Should Make Right-to-Die Decisions?

A combination of ethical principles and legal precedent will largely guide determinations about who should decide in right to die decisions. It seems appropriate, therefore, to consider the issue under ethical aspects.

Though similar ethical principles will probably apply in most such cases, circumstances will vary from one case to another, such that the weighting given to the different principles will vary. In the case of a suicidal adolescent in therapy, the two potential decisionmakers are the client and the psychologist. Some might argue that it is the adolescent's right to exercise self-determination even over his or her life, and hence give priority to autonomy. Many others would no doubt argue that paternalistic intervention is justified because of a) the potential magnitude and irreversibility of the consequences and b) doubts about the person's competence at this point. If unable to obtain firm assurance of a willingness to avoid any further attempt at suicide, paternalism would appear to ethically justify the imposition of a "Mental Health Hold". Of course, the legal basis is normally clearly spelled out for such a decision. Beneficence over-rides autonomy when people pose a "clear and imminent danger to themselves..." The APA's Ethical Principles of Psychologists is also

clear (Principle 5) that when observing client confidentiality "would result in clear danger to the person", breaking it may be justified. Thus, a psychologist working with a suicidal client may be both legally and ethically justified, and legally required at times, to involve parents and/or others.

How does the position differ in refusal of life-prolonging decisions? Here the psychologist will normally function as part of a team, with decisionmaking input, but not primary responsibility.

Where the patient is competent, most believe that primary decision-making responsibility, but not an absolute right, should reside with the patient (See court decisions under Competency below). In other words, autonomy will usually be judged to have precedence. In the grayer area of decisionmaking with incompetent people, Ramsey (1981, p. 133) proposes that the decision should be made by physicians.

> "My chief plea is sufficiently clear...The tests for telling whether to discontinue treatments should be clinical or psychological (if these are the proper words for my meaning), not anyone's values."

While one would not lightly take issue with an ethicist of Ramsey's stature, it does seem that he fails to recognize that the decision to elevate medical "facts" to primacy in such cases, is already a value judgement. Further, when all the medical information on patient condition, treatment risks, and prognosis with and without treatment, is in, value judgements will still be made, because one physician will consider the treatment to be indicated, and another will not.

McCormick and Veatch (1980) make a strong case for the family's

primacy in such decisionmaking cases, providing the decision they make does not grossly depart from guidelines of "the patient's best interests". The Supreme Court decision in In the Matter of Karen Quinlan (Weir, 1977) outlines a procedure in cases where the termination of life-sustaining equipment is contemplated for a comatose patient. It suggests that where physicians agree that a patient is irreversibly dying, or treatment offers no hope of a return to a "cognitive, sapient state", and where they agree that the withdrawal of life-sustaining equipment appears justified, with family concurrence and ratification by the hospital's "ethics" (prognosis) committee, such equipment may be turned off, without liability to any party. In such cases this seems a reasonable procedure, provided that the "best interests" of the patient are somehow given prominence. It is a procedure that should prevent the courts from being overwhelmed with decisionmaking responsibilities in such cases. Such a process with incompetent patients proceeds on the basis of paternalism as the dominant ethical principle.

Psychologists may be involved in such processes through their responsibility to patients, or family members, or as ethics committee members. It should be clearly kept in mind that decisionmaking will normally involve ethical, legal and medical components, sometimes economic and religious components, and in the case of adolescents, a developmental component as a special consideration.

LEGAL ASPECTS OF RIGHT TO DIE DECISIONS

Obviously it is important to understand not only the ethical, but also the legal aspects of right to die decisions.

Perhaps the first point to note is that a person's legal right to die

is unclear. Some people may well hold that the title of this paper is a misnomer - there is no right to die! Hegland (1981) analysed a case[1] in which the court ordered blood transfusions to be given to a mother who had refused them on religious grounds, and concluded:

> "The law's traditional view of the sanctity of human life and the importance of the individual's life to the welfare of society deny the individual the right to, in effect, consent to his own death..." (p. 331)

Although this statement does not, in fact, seem justified by the Georgetown decision, it is true that nowhere can we find a clear constitutional or legal statement of a person's right to choose death.

What does appear to have a constitutional basis is the right to refuse treatment. In In the Matter of Karen Quinlan[2], the Supreme Court of New Jersey cites an earlier decision in identifying "the unwritten constitutional right of privacy" as existing in "the penumbra of specific guaranties of the Bill of Rights". It sees the right to privacy as the basis for a right to refuse treatment. Abernethy and Lundin (1980), analysing case law, conclude that the right to refuse treatment most logically derives from the privacy guarantee, rather than from religious guaranties in the First Amendment, which have often been used to justify refusal of blood transfusions.

Veatch (1976) summarizes strongly:

> "There seems to be a clear consensus that the competent adult has the right to refuse treatments in apparently foolish or misguided grounds, even when the treatments may be as common and clearly lifesaving as a blood

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1. Application of President and Directors of Georgetown College, 331 F.2d 1000, (D.C. Cir. 1964).

2. In the Matter of Karen Quinlan, 335 A.2d 647, (N.J. 1976).

> transfusion. This is why so few cases are brought to court where dying patients are trying to avoid the intervention of new and partially successful biomedical technologies that will only delay the inevitable. In those few cases where a patient is still competent and strong-willed enough to put up a fight, the legal counsel for the hospital is intelligent enough to concede that efforts to get a court order will not succeed." (p. 121)

However, a number of restrictions apply to the right to refuse treatment. Abernethy and Lundin (1980) identify three such limitations. Courts have over-ruled the competent patient's refusal of treatment in cases where the decision seriously threatened the well-being of a third party (the Georgetown decision above serves as an example), and also in cases where the patient's refusal is judged to be ambivalent. United States v. George[3], for example, judged a 39 year old father of four to be ambivalent in his refusal of blood transfusions because, though he stated he would not agree to the procedure, he also stated that he would not resist if the court so ordered. The third restriction on rights to refuse treatment involves patients who are judged incompetent to make decisions on their own behalf. Where such a determination has been made, a court-ordered guardian has traditionally been empowered to act in "the best interests" of the patient.

Apart from these major restrictions it appears fairly well established by now that a person does have a legal right to refuse, even life-saving, treatment.

The Issue of Competence

The issue of competence is a particularly relevant one for the decisions of caregivers working with adolescent clients or patients. How is competency

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3. United States v. George, 239 F. Supp. 753, (D. Conn. 1965).

determined? And who should determine it? Roth, Meisel, and Lidz (1977) have outlined the widest range of approaches to determining competency so far. Basically, they conclude that the standard used to determine competence should rise with the importance of the potential consequences of the decision. Thus, the ability to make a choice at all might be used as evidence of competency when the treatment decision is of small consequence. In contrast, a life or death decision might require evidence of actual understanding of the issues central to the decision the patient is making. The authors warn:

> "The search for a single test of competency is a search for a Holy Grail. Unless it is recognized that there is no magical definition of competency to make decisions about treatment, the search for an acceptable test will never end...In practice, judgments of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine." (p. 283)

It would be remiss to suggest that evidence of competence guarantees court support in treatment-refusal cases. Courts, and ethicists, have in the past, also interested themselves in issues such as the nature of the patient's illness (Is he or she curable, terminal, or dying?), the nature of the patient's illness (prognosis and "quality of life" issues), and the nature of the proposed treatment (Is it "ordinary" or "extraordinary"?). Answers to these questions have played a part in court decisions at times.

We are now at a time where it is widely accepted that "optimal care does not mean maximal treatment, and prolonging life is not the same as prolonging dying." (Beauchamp and Childress, 1979, p. 120). In addition, the obligation to use "extraordinary" treatments, defined by Kelly (1951) as "medicines, treatments and operations which cannot be obtained or used without excessive expense, pain or other inconvenience, or which, if used

would not offer a reasonable hope of benefit" (p. 550), has been more seriously questioned, at least since the Supreme Court's decision in the Karen Quinlan case. Nonetheless, in decisionmaking, issues of competence remain central.

Competence and Adolescents

Legally, all adolescents of sound mind are accorded majority status in the U.S. at the age of 18, with the exception of adolescents in Alabama and Wyoming, where the age is set at 19, and Missouri and Mississippi, where the age is 21 (Rosoff, 1981). Below these ages, adolescents are legally minors, requiring parental, or other vicarious, consent for major treatment decisions. Two exceptions to this policy should be noted. First, most states recognize the concept of an emancipated minor. This is an adolescent who, though below the age of majority, is accorded majority status because he or she fulfills other criteria. The most common of these include: being married, being a parent, living apart from parents and managing own finances, and serving or having served in the armed forces. Secondly, most states have enacted legislation allowing minors to seek specific consultation or treatment in areas such as contraceptive advice, pregnancy testing and venereal disease treatment, in the absence of parental knowledge and/or consent. Though majority or emancipation has written application usually only to rights to treatment, it obviously also has unwritten application to refusal-of-treatment rights.

It is interesting to note that courts have not interpreted the age of majority as a basis for always denying the competence of minors. Veatch (1976) cites the case of a 16 year old girl dying of an osteogenic sarcoma (bone cancer), whose refusal of leg amputation was supported by the courts,

Although the mother's acquiescence was noted, the girl's own wishes were treated as crucial. Veatch (1976) raises for consideration: "...maybe older minors are old enough to consent or refuse consent to some things even before they are old enough to vote or be drafted" (p. 149).

In another case, cited by Veatch (1976), a 16 year old boy with paralytic scoliosis, with a 94 percent curvature of the spine was recommended by physicians for spinal fusion. Because of religious beliefs, the boy's mother agreed to the treatment for her son but refused permission for blood transfusions. The case went eventually to the Supreme Court in Pennsylvannia, where the judge expressly requested that the boy's wishes should be determined and taken into account in the decision.

Noting this tendency to extend the boundaries of competence, at least into the ranks of older adolescents, Veatch (1976) issues a caveat; "The age for competency to refuse lifesaving treatment may not be the same as the age for refusing trivial, experimental, or death-prolonging treatments" (p. 150).

With the above ethical and legal foundation, consider the following cases.

PART II

Applications

Case 1[4].

Tony S. is 18 years old. His mother is a welfare recipient. Several years ago, Tony was involved in a diving accident which left him a quadriplegic, requiring considerable hospital care. Tony has made a good adjustment to his restricted life over the last three years. He gets around

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[4]. Adapted from Oden, 1976.

in an electric wheelchair, has enrolled in a vocational rehabilitation program using computers, has maintained many friendships and built some new ones.

A few weeks ago Tony suffered a serious cardiac malfunction. He was resuscitated and, following initial heart surgery, was placed on a respirator where he remains. He has been conscious now for three days. It appears that he will require several major heart operations, but his prognosis is good. His earlier accident left no cognitive impairment, and there does not appear to be any now. However, since his mother's recent visit he has communicated with staff and indicated that he wants the respirator turned off. He has conveyed to them that he wants to die. Because of his previous record of adjustment, the request is unexpected.

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Case 2[5].

Karen was a 16 year old with a three year history of chronic and acute kidney failure. Surgery was performed to remove both her kidneys, and she received a transplant from her father. Despite initial apparent success, the kidney failed to function after some months, and Karen once again began the treatment regime, which involved hemodialysis three times per week. The family exhibited signs of stress with the father apparently trying "to lose himself" in work, and the mother evidencing other signs of stress reaction. Karen was assessed as suffering a reactive depression, which the psychiatrist judged to be appropriate in the situation.

Some time after the failure of the transplanted kidney, both Karen and her parents began to speak with staff about a wish to discontinue treatment and "let nature take its course". Staff generally were distressed

[5]. Adapted from The Hastings Center Report, 4, 4, 1974, 8-10.

at this, and tried to persuade Karen and her family to continue. The social worker and psychiatrist who had worked throughout with Karen, attempted to have the family fully process the decision, and its significance. Karen did continue treatment.

Six weeks later a high fever developed and Karen was hospitalized again and the transplanted kidney removed. At this time it was ascertained from pathology reports that there was virtually no hope of a future successful transplant. Shortly after, the shunt in Karen's arm, used for dialysis, became infected and had to be surgically altered. Although reluctant to allow the surgery, Karen eventually agreed to have it done. When the shunt clotted closed three days later, the family and Karen refused any further surgery on the shunt area, and refused to continue hemodialysis.

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DISCUSSION

While these two cases contain many similarities, there are also relevant differences. Consider, first, the case of Tony.

Tony has requested that the respirator be turned off; he no longer wishes this treatment but indicates he wants to die. It is important in making an ethical determination, that the autonomous nature of the request be examined. At 18 years of age, developmental issues do not appear to be particularly important, since Tony is presumably no longer a minor. Rather, the burden is on anyone who would refuse his request to show that the decision is not autonomous. If this can be argued then there may be ethical justification for paternalistic intervention - continuing Tony's treatment and maintaining his life, against his expressed wish.

Is there any evidence that Tony's decision may not be autonomous? The answer is not immediately clear from the case as presented, but certainly there are some indications that his decision may not be a competent one. Following the guidelines proposed by Roth, Meisel and Lidz (1977), the assessment of competence here should be stringent, since the potential consequences of the decision are life or death for Tony. It needs to be ascertained whether or not, for example, the decision reflects a temporary state of depression, a concern about the cost burden of prolonged heart surgery for a mother who is on welfare, a reaction to some disagreement with his mother in her recent visit, a lack of understanding of his prognosis, a fear of the surgeries still to be faced - in other words, anything other than a rational decision, carefully thought through, which will stand the test of time. At this stage evidence is lacking to help make this judgement. However, it does appear that the decision is unexpected - Tony's prior adjustment seemed satisfactory. To some extent this appears to be an "out of character" decision for Tony, though it needs to be kept in mind that the current situation is still fairly new for him. Nevertheless, there does appear to be sufficient indication that his decision may reflect temporary incompetence.

Even so, there is no automatic right for paternalism to take precedence. What is the hospital actually offering Tony? What does the continuation of the respirator and subsequent operations hold out for him? What costs and benefits are there? If the costs are high and benefits low, or uncertain, there is still little ethical justification for over-riding his expressed wish.

Tony's prognosis, with the operations, we are told is good. Apparently there is hope that the heart problems can be corrected through surgery, so

that he can resume life as a "normal quadriplegic". If he has potentially years of life ahead of him, and has in the past made a reasonable adjustment to the limitations of a quadriplegic, the benefits might be judged to be quite high. Obviously, the quality of life for a quadriplegic need not be unbearably poor.

How can the costs of continuing treatment for Tony be measured, and how will we decide it the benefits outweigh them? The costs of proceeding will certainly include pain, depression at times, and financial hardship for his mother. Yet, in acknowledging these, we are not entirely helpless. Pain can be alleviated, at least in some measure; through therapy, relationships, and the integration of worthwhile activity, depression can be lessened and lifted; and financial support can surely be found somehow. There do appear to be reasonable grounds for seeing the potential benefits of treatment as outweighing these costs.

Based on the information provided, then, it does appear that ethical support for, at least, temporary denial of Tony's request can be found.

The case of Karen is similar in that it involves an adolescent who expresses the wish to cease treatment, knowing that this will inevitably lead to death. However, Karen is only sixteen years old, so developmental considerations <u>are</u> relevant. Legally she is a minor but she is in that "gray band" where courts have occasionally recognized adolescent competence in previous cases.

Cognitive development research provides, at best, mixed support for the extension of competence into the ranks of older adolescents, so its relevance is uncertain. While early Piagetians claimed that formal oper-

ations was obtained by all during adolescence, later research has shown this not to be so (e.g. King, 1977). But, then, other studies have shown that not all middle-aged adults have achieved formal operations either (e.g. Kuhn, Langer, Kohlberg and Haan, 1977). It would be helpful to be able to claim that "all 16 year olds are formal operational" but apparently this is not so. Why might the attainment of formal operations be relevant? Simply because this level of thinking is normally thought to be a necessary prerequisite to one's "Grasping... the possibilities and limitations of one's self in relation to a finite future..." (Schowalter, Ferholt and Mann, 1976).

Farley (1979) has collected evidence which suggests that no significant change in views of death takes place in the age period 15 to 17.5 years. This is interesting in that it approximates the "gray band" - older adolescents between 15 and the age of majority. Of course, Farley's conclusions derive from mean scores and do not suggest that changes may not occur for the individual. When an adolescent such as Karen makes a decision that will inevitably lead to her death, it would seem important to try to assess her understanding of death's meaning and her awareness of its permanence.

It must be of some concern that Karen has been judged to be suffering a mild reactive depression, albeit one that is considered appropriate in the situation. It is also relevant that both parents have exhibited signs of stress. Are these indications sufficient to justify questioning Karen's decision on the grounds of incompetence, and her parent's decision on similar grounds. (This does not appear to have been questioned in past considerations of this case (Schowalter et al., 1976; The Hastings Center

Report, 1974).) A determination is difficult in the absence of more explit cit data. Note that we cannot rule the decision as incompetent simply because it is made under conditions of stress, or depression. If so, we would be ruling our people's right to autonomy under such conditions. We may note that a social worker and a psychiatrist, both with previous experience with Karen, apparently worked at helping her consider the decision as fully as possible. We may also note that the decision remained firm apparently for a period in excess of six weeks, at which time the decision was translated into action. These factors offer support for seeing this decision as probably a competent one - despite the reactive depression.

It is important that Karen's decision is in accord with her parent's. There is no suggestion that the parents have exerted their wills over Karen. What seems apparent is that together the family has talked about this decision - something many families in similar positions would probably avoid. The decision may be seen as a competent one, exercised by one whom the courts would normally consider a minor, supported by the decision of those whom the courts would normally appoint as the surrogate decision-makers.

But, even, so, this is a life and death decision - perhaps there is a case for paternalism to over-ride such a choice. What does the hospital have to offer Karen? More of what she has apparently decided is too painful, too undignified, too hopeless. Of course, they can extend her life, but it is uncertain for how long, and it seems apparent that she doesn't want her life as it is to be extended. They can offer no hope that her extended life will differ in quality from life as it now is for Karen. At this point the case is different from that of Tony. The hospital can offer him a future that will be different. It cannot take

away his quadriplegia, to which he has demonstrated adequate adjustment in the past. But it can bring him, presumably, to a point where heart operations and respirators are a thing of the past. This the hospital cannot do for Karen. For her, potential benefits appear to revolve around an extended life of the kind she now lives, and must be judged accordingly, to be limited.

Karen is not dying, but she <u>is</u> terminally ill. Hemodialysis cannot cure her, though it can prolong her life. The cessation of treatment will not directly kill her; uremic poisoning will. Her action is not suicide; it is a rejection of life prolongation.

One other important distinction between the two cases needs to be made. Acceding to Tony's request would require somebody to turn off the respirator. Recognizing the autonomy of Karen's decision, in the nature of these cases, does not require any such action. She herself has taken the action in refusing further treatment. To take the other side: opposing Tony's decision requires that no action be taken (at least initially) by the hospital; opposing Karen's decision would require, most likely, a court ordered continuation of treatment. Perhaps the point is a warning. It is easier to accede to the patient's decision in a case like the latter, and for this very reason, one should be doubly careful that the final decision is an ethical one, not one of convenience. It does not appear to be a decision of convenience in Karen's case.

In summary, there is some evidence to suggest that Karen's decision is a competent one. In the absence of other extenuating factors, some people (e.g. Beauchamp and Childress, 1979) would see no justification

for beneficence to over-ride autonomy in such a case. However, even when one does not accept their argument, the apparent ratio of benefits to costs in the case of Karen, does not appear significant enough to justify over-riding her decision.

CONCLUSION

It is likely that psychologists will increasingly be involved with cases such as those above. As indicated earlier, much of their involvement will be at the level of providing counseling, assessing competence and, where cases go to court, appearing as expert witnesses.

It is also obvious that in all right to die cases involving a psychologist, he or she will function professionally as a caregiver. Whatever other roles might be taken, the psychologist will be expected to form the best rapport possible with the person, to attempt through empathy, respect and genuineness to enter and understand the other's world at a significant level, and to aid realistic exploration of all respects of the proposed decision and its alternatives.

It is essential to understand that, regardless of the specific role, the psychologist is required to function as an ethical person. And this requires, in Hare's (1981) model, not merely the ability to intuitively make the "right" decision, but also the ability to critically reflect on relevant ethical principles and the force of these in the given situation.

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